Department of Vermont Health Access
Pharmacy Benefit Management Program
DUR Board Meeting Minutes
February 21, 2017

Board Members:

Present:

Zail Berry, MD	Clayton English, PharmD	Bill Breen, RPh
Alisson Richards, MD	Meghan Groth, PharmD	Louise Rosales, NP

Absent:
Patricia King, MD

Staff:

Jacquelyn Hedlund, MD, Change Healthcare	MaryBeth Bizzari, RPH, DVHA	Laurie Brady, RPh, Change HealthCare
Nancy Hogue, PharmD, DVHA	Jennifer Egelhof, DVHA	Stacey Baker, DVHA
Jason Pope, DVHA	Carrie Germaine, DVHA	
	Cheryl Skaar, Pharmacy Intern, DVHA	

Guests:

Thomas Algozzine, Novartis	Thomas Currier, Purdue	Terry Lee, Gilead
Russell Moyer, Viiv Healthcare	Adam Denman, GSK	Megan Walsh, Abbvie

1. Executive Session:

- An executive session was held from 6:00 p.m. until 6:25p.m.

2. Introductions and Approval of DUR Board Minutes:

- Introductions were made around the table.
- The January meeting minutes were accepted as printed.

3. DVHA Pharmacy Administration Updates: Nancy Hogue, PharmD, DVHA

- Announced that this is the last meeting for Meghan Groth, PharmD as she has taken a new job out of state.
- DVHA has been working hard to recruit more board members. One member is close to approval and should be present at the April meeting.
- DVHA is also recruiting for a new medical director.

4. Medical Director Update:

- No update at this time.

5. Follow-up Items from Previous Meetings: Laurie Brady, RPh, Change Healthcare

- **Data presentation required for Act 172, Sec. E.306.11 Prescribing Practices; Drug Utilization Review Board; Report**

  - The Drug Utilization Review Board in the Department of Vermont Health Access shall analyze data from prescriptions dispensed to Medicaid beneficiaries, including prescriptions written to treat mental health conditions, to determine whether health care providers routinely follow the U.S. Food and Drug Administration's recommended dosage amounts. The Drug Utilization Review Board shall report its findings and any recommendations to the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations and on Health and Welfare. DVHA, in conjunction with Change Healthcare, analyzed 6 medications based on their rank in the list of top 10 drugs by cost and/or volume for State Fiscal Year 2017. Drug databases Clinical Pharmacology and Micromedex Solutions were used to determine the maximum recommended FDA doses. The methodology for defining a claim as exceeding the maximum FDA recommended dose was one prescription's quantity divided by its days' supply. For example, if a member filled 90 Sertraline 100mg tablets for a 30 days' supply, it was assumed that the member was using 3 tablets per day for a total daily dose of 300mg. Because this is above the threshold of 200mg/day, the claim would be considered above the FDA max. Claims were also examined over time looking for overlapping dates of service to capture members on more than one strength of the same medication at the same time.

    During the period analyzed, there were 2469 paid claims for Abilify® dispensed to 591 patients. Twenty-four (0.97%) of these claims were over the FDA approved maximum dose. The claims that exceeded the FDA recommended dose were dispensed to 7 patients. These patients are 1.18% of the total patients receiving Abilify®. There were a total of 12,795 claims for Clonazepam dispensed to 2951 patients. Of these

claims, 365 (2.85%) exceeded the FDA recommended maximum dose which represents 2.8% of patients. A total of 46 Medicaid patients received Harvoni®, consisting of 142 claims. Zero of these claims exceeded the FDA approved maximum dose. There were a total of 20,944 claims for ProAir® HFA dispensed to 12,683 patients. Of these claims 1,301 (6.21%) exceeded the FDA recommended maximum dose. These claims resulted in 912 patients (7.19%) receiving ProAir® HFA at doses that exceeded the FDA recommended maximum dose.
There were a total of 16,035 claims for Sertraline dispensed to 6,010 patients. Fifty-three of those patients (0.88%) received doses that exceeded the recommended FDA maximum resulting in 162 paid claims. This represents 1.01% of all Sertraline paid claims. There were a total of 47,803 claims for Suboxone® films dispensed to 2810 patients. There were 28 claims for 20 patients that exceeded the FDA recommended maximum dose. Therefore, 0.71% of patients and 0.06% of claims exceed the FDA maximum recommended dose.

- The board discussed the following concerns: interactions may lead to increased dose requirements (i.e., CYP inducers); doses above FDA max are commonly used in psychiatry; use of doses above FDA maximums are based on clinical evidence and guidelines (literature).
- The relatively low percentages are not believed to be clinically significant by the board. The board agrees that it is not necessary to further analyze these numbers and do not believe that prescribing over the FDA max is contributing substantial to drug costs. As part of the discussion on Suboxone®, the Board expressed a more general interest in evaluating the quantity limits on controlled substances, although concern was raised that overrides would be needed when proper clinical documentation was provided. DVHA currently has quantity limits on many, but not all controlled substances, and dose-consolidation limits on Suboxone® films (least number of strips to obtain dose). DVHA agreed to revisit quantity limits on controlled substances during 2017.

Board Decision: No further action needed.

6. RetroDUR/DUR: Laurie Brady, RPh, Change Healthcare and Jacquelyn Hedlund, MD Change Healthcare

- **Introduce: Adherence to Guidelines for Monitoring DMARD's**

  Conventional (non-biologic) disease modifying anti-rheumatic drugs (DMARDs) are used to treat a variety of rheumatologic conditions. The goals of using these immunosuppressant medications are: induce or maintain a remission; reduce the incidence of disease flares or relapse; and allow a reduction in the use of glucocorticoids while controlling disease. The DMARDs work in several ways. Some are cytotoxic, and some inhibit steps in the pathway that promotes inflammation. Still others work by inhibiting lymphocyte production or function. All of these drugs have the potential to cause significant toxicity and use must be monitored carefully. The traditional DMARDs are methotrexate (hepatic, renal and hematologic toxicity), hydroxychloroquine (ocular toxicity), sulfasalazine (hematologic toxicity) and leflunomide (hematologic, hepatic and renal toxicity). While not considered traditional DMARDs, the non-biologic drugs cyclosporine and mycophenolate (hepatic, renal, hematologic, vascular toxicity) and azathioprine (hematologic, hepatic toxicity) will be considered here too since the use of these drugs is not uncommon.

  We will use paid, non-reversed pharmacy and medical claims from 2015 and 2016 (excluding members with Part D, VMAP, and Healthy Vermonters coverage) and identify members who are prescribed one of the DMARDs (methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, azathioprine, cyclosporine, mycophenolate). Per guidelines, we will examine medical claims to document measurement of CBCs, LFTs and creatinine at least once in members on all medications except hydroxychloroquine. For members on hydroxychloroquine, we will look to see that at least one eye exam was done while the member was taking the drug. In addition, we will track any potential gaps in care and the prescribers to see if there are opportunities for education.

Board Decision: N/A

- **Data presentation: Methadone use after implementation of Prior Authorization**

  The safety of methadone, a synthetic opioid narcotic used to treat opioid addiction and chronic pain, has been questioned in recent years, as there has been a large increase in the number of deaths from methadone-related overdose. The increase in deaths has been substantially higher than for any other opioid medication and is attributed to a sharp rise in prescribing methadone for chronic pain. In response to these concerns, effective July 8,

2014, The Department of Vermont Health Access (DVHA) implemented a prior authorization for Methadone and limited initiation doses to 30mg per day. Current users were grandfathered until January 1, 2015 before prior authorization was required.

The number of Methadone claims was calculated as well as the number of distinct members who had at least one claim for Methadone. The results were divided into two time frames, SFY2013/14 and SFY2015/16, which represents approximately 2 years prior to PA requirements and 2 years after. We also looked at concurrent use with other opiates. A breakdown of members per physician was also done to assess prescriber trends.

Results include claim counts, number of members, and the average daily dose for the two time frames analyzed. There was approximately 20% decrease in the number of claims and 35% decrease in the number of members prescribed Methadone between the two time frames which would suggest that the prior authorization process has been effective. The number of providers who prescribed Methadone as well as the number of members each prescriber treated. There were a total of 339 prescribers in SFY 2013/14 compared with 273 prescribers in SFY 2015/16, indicating there has been a decrease in the number of Methadone prescribers as well. The majority of prescribers for both time frames treated less than 5 patients. The number of members prescribed Methadone who also had another active opiate prescription at the same time. For SFY 2013/14, 69.90% of members were on another opiate. For SFY 2015/16, 66.07% of members were an another opiate representing a slight decrease between the two time frames.

Implementing a prior authorization for Methadone has resulted in a decrease in the number of claims, members, and prescribers. Further analysis would be needed to determine if members were tapered off the medication or transitioned to another long acting opiate.

Board Decision: The board would like to see per member per month (PMPM) numbers.

7. Review of Newly-Developed/Revised Clinical Coverage Criteria and/or Preferred Products: Laurie Brady, RPh Change Healthcare

- Typical anti-psychotics

- Move Chlorpromazine, Fluphenazine, Thiothixene, and Thioridazine oral to non-preferred.
- Add Molindone to non-preferred.
    - Clinical criteria
        - Chlorpromazine: patient has a diagnosis of acute intermittent porphyria or intractable hiccups OR patient has had a documented side effect, allergy or treatment failure with at least three preferred products (may be typical or atypical anti-psychotics).
        - All other oral medications: patient has had a documented side effect, allergy or treatment failure with at least three preferred products (may be typical or atypical anti-psychotics). If a product has an AB rated generic, one trial must be the generic.

Board Decision: The Board unanimously approved the above recommendation with an amendment to Fluphenazine criteria. They would like fluphenazine conc. to be approved in patients with a medical necessity for a liquid formulation (e.g. patients with a G-tube). They would like fluphenazine tablets to be approved for patients transitioning to decanoate injection and for those on decanoate requiring supplemental dosing.

8. Clinical Update: Drug Reviews: Jacquelyn Hedlund, MD Change Healthcare and Laurie Brady RPh, Change Healthcare

Abbreviated New Drug Reviews:

- None at this time.

Full New Drug Reviews:

a) Byvalson® (nebivolol & valsartan)

- Byvalson® is a fixed-dose combination tablet that contains nebivolol (a β-adrenergic receptor blocking agent) and valsartan (blocks the binding of angiotensin II to the AT1 receptors in tissues such as vascular smooth muscle). It is indicated for the treatment of hypertension, to lower blood pressure. It may be used alone or in combination with other antihypertensive agents. It was shown to be significantly more effective than placebo for lowering mean SBP and DBP, as well as having significantly greater reductions as compared with valsartan 80mg or nebivolol 5mg monotherapy. Byvalson® has a box warning regarding the increased risk of fetal toxicity with use. When pregnancy is detected, treatment should be discontinued as soon as possible. Increases in serum potassium may be seen, and monitoring is recommended during therapy. While there is some evidence to support that Byvalson® is more effective than its individual ingredients when used as monotherapy, there is no evidence at this time to support that Byvalson® is safer or more effective than the currently

available medications or the combination of its individual ingredients or other combination products.

Recommendation:

- Add Byvalson® to non-preferred.
  - Clinical criteria
    - Byvalson: The patient must have a documented side effect, allergy, or treatment failure to at least 3 preferred beta blockers and a preferred ARB used in combination AND is unable to take Bystolic and valsartan as the individual separate agents.

Board Decision: The Board unanimously approved the above recommendation.

b) Otovel® (ciprofloxacin & fluocinolone solution)

- Otovel® is a combination ear solution that contains ciprofloxacin (a fluoroquinolone antimicrobial antibacterial) and fluocinolone acetonide (a corticosteroid that inhibits the local biosynthesis of prostaglandins). It is indicated for the treatment of acute otitis media with tympanostomy tubes (AOMT) in pediatric patients (aged 6 months and older) due to *Staphylococcus aureus*, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Moraxella catarrhalis*, and *Pseudomonas aeruginosa*. Prolonged use of Otovel® may result in overgrowth of non-susceptible bacteria and fungi. If the infection is not improved after one week of treatment, it is recommended to obtain culture to guide further treatment. The combination drops were shown to be significantly more effective than either active treatment alone for cessation of otorrhea. Clinical studies were not found that compared Otovel® with other combination otic treatments. While there is evidence that Otovel® is more effective than each individual ingredient alone, there is no evidence at this time to support that Otovel® is safer or more effective than the currently available combination medications.

Recommendation:

- Add Otovel® otic solution with quantity limit 28-unit dose packages/7 days to non-preferred.
- Add Floxin® otic solution to non-preferred.
  - Clinical criteria

- All non-preferred products: The patient has had a documented side effect, allergy, or treatment failure to two preferred products.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

c) Qbrelis® (lisinopril oral solution)

- Lisinopril, the active ingredient of Qbrelis®, is a long-acting angiotensin converting enzyme (ACE) inhibitor. It is indicated for the treatment of hypertension in adults and pediatric patients ≥6 years (it may be used alone or with other antihypertensive agents); *AND* to reduce signs and symptoms of systolic heart failure; *AND* for the reduction of mortality in the treatment of hemodynamically stable patients within 24 hours of acute myocardial infarction (patients should receive, as appropriate, the standard recommended treatments such as thrombolytics, aspirin, and beta-blockers). Zestril and Prinivil® tablets are both lisinopril products that have been FDA approved for many years and generic lisinopril is also available, while Qbrelis® oral solution is a lisinopril product that was FDA approved in 2016. All lisinopril products have the same FDA approved indications as Qbrelis®, but Qbrelis® now provides an alternative dosage formulation. There is no evidence at this time to support that Qbrelis® is safer or more effective than the currently available medications.

Recommendation:

- Add Qbrelis® to non-preferred.
- Move Captopril to non-preferred.
- Move Moexepril to non-preferred.
- Remove Aceon and Univasc as these products are no longer available.
    - Clinical criteria
        - Qbrelis Oral Solution: patient has a requirement for an oral liquid dosage form (i.e. swallowing disorder, inability to take oral medications) AND has a side effect, allergy, or treatment failure to Epaned oral solution.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

d) Viekira® XR (dasabuvir, ombitasvir, paritaprevir, & ritonavir tabs)

- Viekira® XR is a fixed-dose combination tablet that includes a hepatitis C virus (HCV) non-nucleoside NS5B palm polymerase inhibitor (dasabuvir), a HCV NS5A inhibitor (ombitasvir), a HCV NS3/4A protease inhibitor (paritaprevir), and a CYP3A inhibitor (ritonavir) that inhibits CYP3A mediated metabolism of paritaprevir to provide increased plasma levels of paritaprevir. Dasabuvir, ombitasvir, and paritaprevir are directing-acting HCV antiviral agents with distinct mechanisms of action, while ritonavir is not active against HCV. It is indicated for the treatment of adult patients with chronic hepatitis C virus (HCV):
    - genotype 1b infection without cirrhosis or with compensated cirrhosis
    - genotype 1a infection without cirrhosis or with compensated cirrhosis for use in combination with ribavirin.

  Significant drug interactions need to be monitored while on this product. In addition, use is contraindicated with moderate and severe hepatic impairment. The safety and efficacy of the components of Viekira® XR with or without ribavirin were established in numerous randomized, multicenter studies. Of note, these are the same studies used to establish the safety and efficacy of Viekira® Pak. The studies do suggest potent antiviral activity in a population with HCV genotype 1 based on significantly high SVR rates. The evidence-based IDSA/AASLD Hepatitis C guidelines are frequently updated and include several recommended regimens. Hepatitis C treatment is a rapidly changing therapeutic area and the recommendation for treatment for specific genotypes and clinical situations are continuing to evolve. Determination of the clinically optimal and most effective regimen for Hepatitis C is complex and it is recommended that this drug be non-preferred to determine specific clinical conditions in order to ensure appropriate use.

Recommendation:

- Add Viekira® XR to non-preferred.
    - Clinical criteria
        - Add Viekira XR to the Direct Acting Agents clinical criteria.

Public Comment: No public comments.

Board Decision: The Board unanimously approved the above recommendation.

e) Zinbryta® (daclizumab)

- Zinbryta® is a humanized monoclonal antibody that binds to the alpha sub-unit of the interleukin-2 receptor (IL-2Rα, CD25). While the exact mechanism of action for use in multiple sclerosis is not known, it is thought to involve modulation of IL-2 mediated activation of lymphocytes through binding to CD25, a subunit of the high-affinity IL-2 receptor. It is indicated for the treatment of adult patients with relapsing forms of multiple sclerosis (MS). Due to its safety profile, the use of Zinbryta® should generally be reserved for patients who have had an inadequate response to two or more drugs indicated for the treatment of MS. Zinbryta® has a box warning regarding the increased risk of hepatic injury. It is recommended to obtain serum transaminases (ALT and AST) and total bilirubin levels prior to starting treatment, during treatment, and then monthly for 6 months after the last dose. Zinbryta® is only available through a restricted program called the Zinbryta® REMS Program. There is some evidence at this time to support that Zinbryta® is more effective than Avonex® in regards to the annualized relapse rate. Nevertheless, it is indicated that, due to its safety profile, use should generally be reserved for patients who have had an inadequate response to two or more drugs indicated for the treatment of MS.

Recommendation:

- Add Zinbryta® with quantity limit 1 syringe/ 30 days to non-preferred.
- Add Rebif® Rebidose to preferred.
    - Clinical criteria:

      Zinbryta: Patient has a diagnosis of relapsing multiple sclerosis and has already been stabilized on Zinbryta OR Patient is ≥18 years of age AND Diagnosis is relapsing multiple sclerosis and the patient has a documented side effect, allergy, treatment failure, or contraindication to at least three other MS agents, two of which must be preferred AND the patient does not have pre-existing hepatic disease or hepatic impairment (LFT monitoring is recommended prior to starting therapy, monthly during therapy, and for at 6 months after stopping therapy) AND the physician, pharmacy, and patient are enrolled in the Zinbryta® REMS program.

Public Comment: Franco Casagrande from Abbvie: Highlighted the attributes of Zinbryta®.

Board Decision: The Board unanimously approved the above recommendation.

f) Zurampic® (lesinurad)

- Lesinurad, the active ingredient of Zurampic®, reduces serum uric acid levels by inhibiting the function of transporter proteins involved in uric acid reabsorption in the kidney. It inhibits the function of 2 apical transporters responsible for uric acid reabsorption, including uric acid transporter 1 (URAT1) and organic anion transporter 4 (OAT4). URAT1 is responsible for most of the reabsorption of filtered uric acid from the renal tubular lumen, while OAT4 is a uric acid transporter associated with diuretic-induced hyperuricemia. Zurampic® is indicated for use in combination with a xanthine oxidase inhibitor for the treatment of hyperuricemia associated with gout in patients who have not achieved target serum uric acid levels with a xanthine oxidase inhibitor alone. Zurampic® is not recommended for the treatment of asymptomatic hyperuricemia and should not be used as monotherapy. In two clinical trials that included patients with an inadequate response to allopurinol, Zurampic® in combination with allopurinol was found to be superior to allopurinol monotherapy for lowering serum uric acid to <6mg/dL at month 6. None of the currently reported studies demonstrated that the addition of Zurampic® significantly reduced the rate of gout flares needing treatment or increased the rate of tophi resolution from month 6-12 of treatment. There is no evidence at this time to support that Zurampic® is safer or more effective than the currently available medications.

Recommendation:

- Add Zurampic® to non-preferred.
  - Clinical criteria
    - Zurampic: The diagnosis or indication is treatment of symptomatic hyperuricemia associated with gout AND the patient has not achieved target serum uric acid levels (< 6 mg/dl) with an allopurinol dose of at least 300mg or febuxostat 80mg AND the medication is being used in combination with a xanthine oxidase inhibitor (Zurampic is not recommended for use as monotherapy).

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

9. Therapeutic Drug Classes – Periodic Review: Jacquelyn Hedlund, MD, Change Healthcare and Laurie Brady, RPh, Change Healthcare

a) Anti- migraine Triptans

- Zecuity® iontophoretic transdermal system was FDA approved in 2015. It was approved as a topical transdermal treatment for migraine headaches in adults; however, on June 2, 2016 an FDA Drug Safety Communication was disseminated regarding the risk of serious burns and potential permanent scarring with Zecuity® use. As a result, the FDA began investigating these events to determine if regulatory action was needed. Nevertheless, on June 10, 2016, the manufacturer of Zecuity® transdermal revealed that they were going to be suspending the sale, marketing and distribution due to the post-marketing reports of application site reactions depicted as 'burn' and/or 'scar' in patients treated with this product.

Recommendation:

- Add Almotriptan with quantity limit 12 tablets/ month to non-preferred.
- Add Frovatriptan with quantity limit 9tablets/ month to non-preferred.
    - Clinical criteria
        - Almotriptan, Amerge, Frova, Frovatriptan, Imitrex, Maxalt, Maxalt MLT, Naratriptan, Zomig, Zomig ZMT, Zolmitriptan, Zolmitriptan ODT: patient has had a documented side effect, allergy, or treatment failure to Sumatriptan, Relpax, and Rizatriptan or Rizatriptan ODT. If the request is for brand Frova, Maxalt, Zomig, or Zomig ZMT, the patient must also have a documented intolerance to the generic product.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

b) Bone Resorption Suppression and Related Agents

- No new drugs.
- No significant changes.
- It is estimated that osteoporosis affects approximately 75 million people in Europe, the USA, and Japan, with a prevalence of over 10 million people in the US of adults ≥50 years of age. Osteoporosis, the most common bone disease in humans, results in decreased bone strength and an increased risk of fractures. It is estimated that osteoporosis causes more than 8.9 million fractures annually worldwide.

Recommendation:

- Remove Didronel®, Fortical® and Skelid® as they are no longer rebatable.
    - Clinical criteria

- Actonel, Atelvia, Risedronate: patient has a diagnosis/indication of Paget's Disease, postmenopausal osteoporosis, osteoporosis in men or glucocorticoid induced osteoporosis AND patient has had a documented side effect, allergy, or treatment failure (at least a six-month trial) to generic alendronate tablets. AND if the request is for brand Actonel, the patient has also had a documented intolerance to generic risedronate.
- Etidronate: patient has a diagnosis/indication of Paget's Disease AND patient has had a documented side effect, allergy, treatment failure (at least a six-month trial) to generic alendronate and risedronate tablets.
- Xgeva Injection: diagnosis or indication is bone metastases from solid tumors (e.g. prostate, breast, thyroid, non-small lung cancer), hypercalcemia of malignancy, or giant cell tumor of bone.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

c) BPH Agents

- No new drugs.
- No significant changes.
- Benign Prostatic Hyperplasia (BPH) is one of the most common diseases of aging men, generally presenting after the age of 40. BPH increases in prevalence with increasing age, reaching over 80% by the age of 80. The exact etiology of BPH is unknown, though it is thought to result from enlargement of the prostate gland as well as excessive alpha adrenergic tone, which causes a contraction of the prostate around the urethra.
- Treatment goals of BPH include the elimination of bothersome LUTS and the prevention of complications. Depending on disease severity, treatment options may include watchful waiting, pharmacological agents, and/or prostatectomy. There are 3 classes of medications which are effective in the treatment of BPH, including alpha-1 adrenergic antagonists, 5-alpha reductase inhibitors, and PDE-5 Inhibitors

<u>Recommendation</u>:

- Move Alfuzosin ER with quantity limit of 1 tablet/day to preferred.
- Add Dutasteride with quantity limit of 1 capsule/ day to non-preferred.
- Add dutasteride/tamsulosin with quantity limit of 1 capsule/ day to non-preferred.
    - Clinical criteria

- Avodart, dutasteride, Proscar: The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented side effect, allergy or treatment failure to generic finasteride AND for approval of brand Avodart, the patient must have a documented intolerance to generic dutasteride.
- Dutasteride/tamsulosin, Jalyn: The patient has a diagnosis of BPH (benign prostatic hypertrophy) AND the patient has a documented treatment failure/inadequate response to combination therapy with generic tamsulosin and finasteride AND is unable to take tamsulosin and dutasteride as the individual separate agents AND for approval of brand Jalyn, the patient must have a documented intolerance to generic dutasteride/tamsulosin.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

d) Erythropoiesis Stimulating Proteins

- No new drugs.
- No significant changes.
- Erythropoietin (EPO) is a hormone produced in the kidneys that promotes the growth of red blood cells (RBCs) in bone marrow. The cells that make EPO are extremely sensitive to oxygen levels in the blood. When the oxygen level in the blood is low, EPO is released. This stimulates the production of new red blood cells, thus increasing the oxygen-carrying capacity.
- In 2008, the FDA placed new restrictions on ESAs including a Risk Evaluation and Mitigation Strategy (REMS) that placed restrictions on this class of drugs due to safety concerns, including the risk of tumor progression. The REMS includes an informed consent process to ensure patients are aware of the risks and benefits of ESA use. It also requires health care providers who prescribe ESAs for cancer patients to be enrolled in the ESA APPRISE (Assisting Providers and Cancer Patients with Risk Information for the Safe use of ESAs) program.

Recommendation:

- Remove Mircera® as it is no longer rebatable.
- Clinical criteria
- Aranesp, Procrit, Epogen: diagnosis or indication for the requested medication is anemia due to one of the following: Chronic kidney disease/renal failure, Post-renal

transplant, Use of zidovudine for the treatment of human immunodeficiency virus (HIV) (other causes of anemia, such as iron/folate/vitamin B12 deficiency have been eliminated), Surgery patients at high risk for perioperative blood loss, Cancer chemotherapy, Use of ribavirin or interferon therapy for Hepatitis C, Myelodysplastic syndrome. Hemoglobin level at initiation of therapy is <10 g/dL OR for patients currently maintained on therapy, hemoglobin level is < 11 g/dL in dialysis patients with chronic kidney disease, < 10 g/dL in non-dialysis patients with chronic kidney disease, or < 12 g/dL in patients treated for other indications AND for approval of Epogen, the patient has had a documented side effect, allergy, or treatment failure to both Aranesp and Procrit.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

e) Growth Hormones

- No new drugs.
- No significant changes.
- Growth hormone deficiency (GHD) is a medical condition caused by problems with pituitary gland function. The most common causes of GHD are pituitary and extrapituitary tumors. GHD has a variety of negative health effects, including hypoglycemia in newborns, growth failure in later infancy and childhood, and poor bone density in adults.
- There are currently numerous brand name growth hormone products available on the market, but all contain the same active ingredient, somatropin. Nevertheless, they are split into two group types dependent upon whether they were *Escherichia coli* derived formulations or mammalian derived formulations.

Recommendation:

- Remove Tev Tropin® from the PDL as it is no longer available.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

f) Hereditary Angioedema Agents

- No new drugs.
- No significant changes.
- Treatment approaches can be divided into treatment of acute attacks and long term prophylaxis. Acute treatment with plasma derived C1-INH has been available in Europe for over 30 years and has recently been approved in the US (Berinert®). In conjunction with its approval, additional medications targeting the bradykinin pathways (ecallantide and icatibant) have recently come to market, as well as a recombinant version of C1-INH. The expansion of treatment options, as well as the ability of patients to provide self-administered treatments, has significantly improved the quality of life for patients with HAE types 1 and 2. Care has shifted from hospitalization to patient-centered home-based treatment targeting the early stages of an attack. Their use has also expanded into a short-term prophylactic use; Cinryze® has been approved for short-term prophylaxis prior to known trigger events such as surgery. All patients should have access to on-demand treatment for 2 attacks and should carry treatment at all times.
- Hereditary angioedema (HAE) is a disorder characterized by spontaneous swelling of the submucosal and subcutaneous tissue typically involving the face, tongue, larynx, extremities, genitals or bowels. It results in significant morbidity and may have significant mortality associated with it as well if laryngeal swelling is present. There are multiple types of HAE, sub-classified as type 1 (low C1-INH levels and low functionality), type 2 (normal C1-INH levels with impaired functionality), and previously labeled type 3 now termed HAE with normal C1-INH activity. These manifestations are a result of an autosomal dominant genetic mutation.
- Zuraw et al representing the HAE Association Medical Advisory Board (HAEA MAB) published US based recommendations for the management of HAE due to C1-INH deficiency in 2013. The HAEA MAB stated that androgenic agents should not be used in patients that have a preference for alternative therapy and patients should not be required to fail androgen therapy as a pre-requisite for prophylactic C1-INH use.

<u>Recommendation</u>:

- Move Kalbitor to non-preferred with quantity limit 6vials (2 packs) per fill.
  - Clinical criteria
    - Berinert, Firazyr, Kalbitor: The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack. (Approval may be granted so that 2 doses may be kept on hand and for Berinert or Kalbitor and 3 doses for Firazyr).

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

g) Phosphate Binders

- No new drugs.
- No significant changes.
- Phosphate binders are one class of medications that help control hyperphosphatemia by inhibiting the absorption of dietary phosphorus from the intestine.

Recommendation:

- Remove Phos Lo capsules from the PDL as they are no longer rebateable.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

10. New Managed Therapeutic Drug Classes

- None at this time

11. General Announcements:

Selected FDA Safety Alerts

- FDA Releases Draft Guidance for Industry: "Considerations in Demonstrating Interchangeability With a Reference Product."-Drug Information Update http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM537135.pdf?source=govdelivery&utm_medium=email&utm_source=govdelivery
- FDA confirms elevated levels of belladonna in certain homeopathic teething products http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm538684.htm?source=govdelivery&utm_medium=email&utm_source=govdelivery
- Chlorhexidine Gluconate: Drug Safety Communication - Rare But Serious Allergic Reactions http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm539575.htm?source=govdelivery&utm_medium=email&utm_source=govdelivery

12. Adjourn: Meeting adjourned at 8:15p.m.